# CLINICAL PRIVILEGE LIST
# OPTOMETRY

(For use of this form, see AFI 44-119, the proponent agency is ANG / SG)

**PRIVACY ACT STATEMENT**

**AUTHORITY:** Title 10, USC, Chapter 55, and Sections 8067 and 8012.

**PRINCIPLE PURPOSE:** To evaluate each practitioners formal education, training, clinical experience, and evidence of physical behavior, moral and ethical capacities in making recommendations with regard to the practitioner's competence to treat certain conditions and perform certain medical procedures.

**ROUTINE USES:** Information may be released to government boards, agencies, or professional societies or organizations if needed to license or monitor professional standards of health care practitioners. I may also be released to civilian institutions or organizations where the practitioner is applying for staff privileges during or after service separation.

**DISCLOSURE:** Voluntary. However, failure to provide information may result in the limitation or termination of clinical privileges.

**INSTRUCTIONS**

List of Privileges: The PRACTITIONER enters the appropriate code number in the block marked REQUESTED. Each block must have a code number. The practitioner signs and dates the form and sends it to the appropriate medical authority.
Reviewer's Action. Requested privileges are reviewed and the appropriate code number is entered in the block marked APPROVED for each privilege. The reviewer then checks one of the bottom, signs and dates the form, and returns it to the credentials monitor.
All requested changes must be initialed in pen. The reviewer will review requested changes and approval / disapproval will be accomplished in pen and the file returned to the credential monitor. The reviewer may request the practitioner to submit a new privilege list.

**CODES**

1 - PERFORM UNSUPERVISED
2 - PERFORM WITH SUPERVISION
3 - PERFORM WITH CONSULTATION
4 - NOT REQUESTED / APPROVED - LACK OF FACILITY SUPPORT
5 - NOT REQUESTED / APPROVED - LACK OF EXPERTISE

| NAME OF PRACTITIONER: | NAME OF MEDICAL FACILITY: |
|---|---|
| | |

**REQUESTED PRIVILEGES**

| REQUESTED | APPROVED | |
|---|---|---|
| | | PERFORM COMPLETED VISUAL EXAMS WITH / WITHOUT DIAGNOSTIC DRUGS. |
| | | PRESCRIBE SPECTACLE LENSES FOR CORRECTION OF REFRACTIVE ERRORS. |
| | | REFER PATIENTS WITH MANIFEST / SUSPECTED PATHOLOGY TO APPROPRIATE SPECIALIST. |
| | | PRESCRIBE NONPRESCRIPTION EYE MEDICATIONS (i.e.;VISINE, ARTIFICIAL TEARS). |
| | | SUPERVISE TECHNICIANS IN REFORMING VISUAL SCREENING PROGRAMS. |
| | | OTHER |

| SIGNATURE OF PRACTITIONER: | DATE: |
|---|---|
| | |

**REVIEWER'S RECOMMENDATION**

☐ RECOMMENDED APPROVAL ☐ RECOMMEND APPROVAL WITH MODIFICATION (Specify Below) ☐ DISAPPROVAL (Specify)

| SIGNATURE OF REVIEWER: | DATE: |
|---|---|
| | |